# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-028666 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7653

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

FILED AUG 13 1962

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b: 6 weeks

c. CITY OR TOWN St. Louis — Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1615 Veronica Ave. — Reside on Farm: Yes ☐ No ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| EDWARD | J. | GIERER | Aug. | 3 | 1962 |

| 5. SEX | 6. COLOR OR RACE | 7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐ | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HR Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | | 1/28/1886 | 76 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Dept. Manager | Banking | St. Louis Mo. | U.S.A. |

| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
|---|---|---|
| Edward J. Gierer Sr. | Krenzenz Geir | Sophia Gierer |

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of servic

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Lucille Frese 1615 Veronica

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line f)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Chron

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arterio Sclerotic Heart Disease — Chron

DUE TO (c) Hypertension 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from several years to Aug 3 1962 and last saw her/him alive on Aug 2 1962

Death occurred at DePaul Hospital 10P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Eugene Kohler MD — 22b. ADDRESS 4965 Wilmington Blvd — 22c. DATE SIGNED 8/4/62

23a. BURIAL, CREMATION, REMOVAL (Specify) buried — 23b. DATE 8/6/1962 — 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery — 23d. LOCATION (City, town, or county) St. Louis (State) Mo.

24. FUNERAL DIRECTOR ADDRESS Buchholz Mortuary 5967 W. Florissant

25. DATE RECD. BY LOCAL REG. AUG 6 1962

26. REGISTRAR'S SIGNATURE Hoard Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED |
|---|---|---|---|
| 1 | | | |
| 2 | 20 | 8 | 2 |
| 3 | | | |
| 4 | 0 | | |
| 5 | 2 | | |
| 6 | | | |
| 7 | 0 | | |
| 8 | 2 | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | 59-0 | | |
| 13 | | | |

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USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed [signature]

Licensed Embalmer No. 4551

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.